PSYCHOLOGY CASE RECORD

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in partial fulfilment of the requirements for the
Diploma in Psychological Medicine
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By
DR. NIVEDITA SUDHEER

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I would like to express my sincere thanks to all the patients and their families who kindly cooperated with me even though they themselves were suffering.

Most of all, I would like to thank The Almighty God for all His blessings.

CERTIFICATE

This is to certify that this Psychological Case Record is a bonafide record of work done by **Dr. Nivedita Sudheer** during the year 2015-2017. I also certify that this record is an independent work done by the candidate under my supervision.

Dr. Mary Anju Kuruvilla
Professor and Head
Department of Psychiatry
Christian Medical College
Vellore 632 002.

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Mrs.Sushila Russell, M.Phil,
Reader in Clinical Psychology
Department of Psychiatry
Christian Medical College
Vellore 632 002.

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CASE RECORD 1: I Q ASSESSMENT

Name	**:** Mr. KR
Age	**:** 28 years
Sex	**:** Male
Marital Status	**:** Single
Religion	**:** Hindu
Language	**:** Tamil
Education	**:** VIII grade
Occupation	**:** Mill worker
Socio economic Status	**:** Lower
Residence	**:** Rural
Informant	**:** Mother

Presenting Complaints

- Delay in developmental milestones
- Age inappropriate behavior
- Poor socialization and unclear speech

History of Presenting Complaints

Mr. KR was brought with complaints of a history of delay in achieving his developmental milestones in comparison with his sibling since the age of ten months. This was reported to be following acute gastroenteritis which required in patient treatment. He was noticed to have difficulty in school in all areas of his functioning. His inability to keep up with his peers in academics and socialization became more pronounced with each grade. He was able to attend classes up to VIII grade but his academic ability was not in keeping with his grade.

He is able to carry out all his activities of daily living such as eating, bathing, grooming and dressing independently and does not need any prompts from his family members to do the same. He is also able to make simple monetary transactions and is able to independently go out to a shop. He is also able to maintain a job in a rice mill. He is able to use a basic mobile phone to make calls and listen to music. He is able to learn simple tasks that do not require him to think and make decisions independently.

At present, he is independent with regards to all activities of daily living, is able to carry out simple monetary transactions and working at a rice mill.

There is no history of behavioural problems or psychosis

There is no history suggestive of a pervasive developmental disorder

There is no history suggestive of psychoactive substance use, pervasive mood syndrome or other anxiety spectrum disorders.

Past History

He has been diagnosed with Kyphoscoliosis with bilateral bronchiectasis, Pulmonary Artery Hypertension with Cor-pulmonale.

He is on follow up with Respiratory Medicine for the same.

Family History

There is no history of any neuro-psychiatric illness in his family. He was born of a second degree consanguineous union. He has an elder brother who is thirty-three years old and works as a software engineer. Mr KR lives with his parents in a nuclear family setting.

Birth and Developmental History

The antenatal period was supervised and was uneventful. His birth was at full term normal vaginal delivery in a hospital. There was no birth asphyxia or neonatal jaundice. The exact details of the developmental milestones were not recalled by the mother. However, a delay in achieving milestones across all

domains is reported, with him being able to walk only by around three years of age and being able to speak in full sentences at around fifteen years of age.

Education History

He has attended school up to VIII standard. He was initially studying in an English medium school till class IV. However, in view of his difficulty in keeping up with his peers, he was changed to a Tamil medium school till class VIII. However, the change did not result in an improvement in his academic performance. He remained below average in his academics. There were no behavioural problems or complaints from his teachers.

Occupation History

Mr. KR works in a rice mill.

Sexual and Marital History

He is as yet unmarried. His sexual history could not be assessed.

Physical Examination

His vitals were stable and his systemic examination was within normal limits. There was no clubbing or cyanosis. There was no pedal edema. Kyphoscoliosis of the chest present. There were no dysmorphic features, no neurocutaneous markers.

Mental Status Examination

He is a moderately built individual and was adequately kempt. He maintained eye contact. Rapport could be established easily. He was alert and lucid through the interview. He was able to follow commands. He was cooperative towards the examiner. His goal directed movements were appropriate and purposeful. His speech was child like, relevant, hesitant, dysarthric with normal reaction time and speed and laconic productivity. His mood was euthymic with normal range and reactivity of affect. He denied suicidal ideation. There were no abnormalities in form and stream of thought. His content of thought did not reveal any delusions or depressive ideations. There were no perceptual abnormalities. He was oriented to time place and person. His immediate, recent and remote memory was intact. His attention could be aroused and sustained. His abstract ability was concrete. His vocabulary was adequate and his arithmetic ability was limited. His intelligence was clinically determined to be sub normal. His personal, social and test judgement was intact.

Provisional Diagnosis

BORDERLINE INTELLIGENCE

Aim of Psychological Testing

In view of the sub normal level of functioning, it was determined to quantify his intellectual ability.

Test Administered

The Binet Kamat Test of General Mental Abilities (BKT)

Rationale for the Test

The BKT is a test of intelligence that has been standardized for the Indian population and assesses a wide range of intellectual abilities.

Behavioural Observation

He was cooperative for the assessment and was able to comprehend the instructions. There was mild performance anxiety observed and he needed reassurance to complete the assessment. His speech was unclear and he had difficulty in communication.

Test Findings

The basal age attained was 7 years; the terminal age was 12 years and the mental age was 8 years and 2 months with the corresponding IQ being 51 indicating mild mental retardation.

His performance on items measuring social intelligence was significantly better than in items measuring reasoning and language.

Impression: Mild intellectual disability

Management

MR. KR and his family were educated about the nature of the condition and about the results of the assessment. Their doubts were addressed and vocational training and rehabilitation were suggested. He was advised to continue to follow up with Respiratory Medicine for his medical problems.

CASE RECORD 2: PERSONALITY ASSESSMENT

Name	: Ms. SCS
Age	: 19 years
Sex	: Female
Marital status	**:** Single
Religion	**:** Hindu
Language	**:** Tamil
Education	**:** B.Com III year
Occupation	**:** Student
Socio-economic status	: Middle
Residence	: Urban
Informant	**:** Ms. SCS and her mother

Presenting complaints

- Behavioural problems since childhood, worsening over the past 20 days

History of presenting illness

Ms. SCS presented with a pervasive, enduring pattern of behaviour, characterized by low tolerance to frustration, low threshold for discharge of aggression, frequent lying, marked proneness to blame others and a tendency to lie for trivial and non-trivial issues. Over the last 1 year there is also a history of her having taken various amounts of money from her mother, without her mother's knowledge. She was also noticed to have an inability to experience

guilt and instances of affective instability, with impulsivity and with behavioural explosions during times of stressors with instances of aggression towards her younger sibling. She has also noted to have a tendency to engage in relationships with males and become extremely sensitive to their responses. There is also history of one episode of deliberate self harm of low intentionality and lethality and high intentionality precipitated by problems in interpersonal relationship with a male friend.

She has been undergoing counselling for the above problems albeit irregularly. However, following worsening of symptoms since the last three months, she presented here for further management.

There was no history of an organic aetiology, substance use, first rank symptoms, manic or depressive syndromes or obsessive compulsive symptoms.

Past history

There was no significant past medical history

Family history

She was the elder of two siblings. Her younger sister was seventeen years old and was doing 12^{th} Grade. Her father was diagnosed with a renal disease and passed away in 2011 due to complications associated with the same. Her mother was a home maker. There was no family history of any neuro-psychiatric illness in her family.

Birth and development history

The antenatal and perinatal periods were uneventful. Her developmental milestones were reported to be normal.

Educational history

She was in the III year of her Bachelor's in Commerce. Her academic performance was average. Her relationship with teachers and peers was cordial.

Occupational history

She has never been formally employed.

Sexual history

She had a heterosexual orientation. She denied high risk sexual behaviour. Her menstrual cycles were regular.

Marital history

She was unmarried.

Premorbid personality

Premorbidly she was said to have been stubborn. Although she was not socially anxious, she did not have many close friends. She enjoyed reading and, occasionally, cooking. She was not a very religious person.

Physical examination

Her vitals were stable and her systemic examination was within normal limits.

Mental status examination

Ms SCS was moderately built, appropriately groomed. Rapport was superficial initially. She maintained eye contact. She was alert and lucid with no fluctuation in consciousness. There were no abnormal motor movements. Her speech was spontaneous with normal tone, speech and pitch with good comprehension. Her mood was dysphoric with normal range and reactivity of affect. There were no abnormalities in the form and stream of thought. Her content of thought revealed feeling of intense sadness related to her father's demise; frustration due to her perception that her sister was being given more importance in her family. She expressed feelings of not being loved since her father's demise. She denied any perceptual or volitional abnormalities. She had no obsessive compulsive symptoms. She was oriented to time, place and person. Her immediate, recent and remote memory was intact. Her attention could be aroused and sustained. Her intelligence was average. She had intellectual insight into her problem. Her personal and test judgement were intact and her social judgement was impaired.

Provisional diagnosis

Mixed personality Disorder- Dissocial and emotionally unstable personality traits

Aims for psychological testing

- To identify and explore significant personality factors influencing the psychopathology
- To utilize the findings in psychotherapy

Tests Administered and Rationale

- **IPDE ICD-10 module Screening Questionnaire**

  Rationale: The IPDE, developed by Dr. Armander B. Loranger and colleagues, is a semi-structured clinical interview that provides a means of arriving at the diagnosis of major categories of personality disorders. The screening questionnaire is a tool used to eliminate individuals who are unlikely to have a personality disorder.

- **16-PF Questionnaire**

  Rationale: It is a self report questionnaire developed by Raymond Cattell and measures the 16 personality traits and the big five secondary personality traits

- **Sack's Sentence Completion Test**

  Rationale: It is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentences, to which the respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

- **Thematic Apperception Test**

  Rationale: It is a projective test intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others.

Behavioural Observation

She was cooperative for the assessment and was able to sustain attention through the session. Due to the want of time, the assessments were conducted over two separate sessions. There was no performance anxiety observed. She was able to comprehend the instructions well. Her verbal communication was adequate.

TEST RESULTS

IPDE ICD-10 module Screening Questionnaire

This screening inventory revealed that she had a high loading on the traits associated with Dissocial and Impulsive personality traits.

16-PF Personality Questionnaire

The 16 PF indicates she tends to be dominant and stubborn in her interaction with others. She does not hesitate to express herself or stand

up for what she believes is right. She has a tendency to disregard rules and authority. She also tends to be controlling in her relationship with others. She tends to be impulsive and act out her frustrations. She has a capacity to be spontaneous and enthusiastic but more often than not, tends to be guarded in her interaction with others and emotionally detached. She prefers to keep problems to themselves rather than discussing with others.

Sack's Sentence Completion Test

It indicates conflicts in the area of family, self and sex. There appears to be significant conflicts in her attitude towards her mother. Although she feels that most mothers are loving towards their children, she expresses a feeling of insecurity in her attachment with her mother. The test also shows that she still is significantly affected by the death of her father, with whom she shared a close bond and considered as her friend. She has overwhelming guilt and feels she could have done more for him. She reminisces about the past and the time spent with her father, yet she seems hopeful towards the future. The test also indicates an overwhelming fear of her uncle but is ambivalent regarding the reason for her fear. She longs for happiness. Her frustration tolerance tends to be low but she has confidence in her abilities and that would achieve her goals in life and would not allow it to hinder her dreams. There also

appears to be some interpersonal conflicts with her friends, who, she feels, speak ill of her. Her attitudes towards sex are conservative.

Thematic Apperception Test

The stories are detailed and well written. The predominant needs which emerge are those of affiliation, nurturance, affection and abasement. The conflicts seen are harm avoidance vs aggression, deference vs dominance, neglect vs affection and abasement vs autonomy and achievement. The major press is societal norms, physical deformities which seem to hold back the characters as portrayed by her. The female characters are portrayed as weak and submissive. The stories portray a theme of strong sense of familial ties and sacrifice by family members for the happiness of the family unit. The predominant emotions that are seen across the stories are of love, sympathy, sadness, despair and envy. The predominant defence portrayed is avoidance and reaction formation.

Impression

The assessment was indicative of the presence of impulsive and dissocial traits such as disregard for rules and authority; a tendency to be dominant in interaction with others and a tendency towards impulsive and acting out behaviours.

Management

Ms. SCS was admitted for diagnostic clarification. A personality assessment revealed dissocial and emotionally unstable personality traits. During the course of her stay, rapport was deepened. Conflict areas were gradually probed. She was receptive to specific suggestions about anger management and the same was discussed. The needs to improve ability to regulate emotions and avoid attempts at self harm were also discussed. Reframing was employed to perceive situations differently. She was discharged after a brief in-patient stay. She continued to follow up regularly for psychotherapy on an out-patient basis.

CASE RECORD 3: DIAGNOSTIC CLARIFICATION

Name	: Ms. AM
Age	: 17 years
Sex	: Female
Marital status	: Single
Religion	: Hindu
Language	: Tamil
Education	: 12th standard
Occupation	: Student
Socio-economic status	: Middle
Residence	: Rural
Informant	: Ms. AM and her parents

Presenting complaints

Repetitive thoughts about whether certain cine actors were dead or alive – 2 and 1/2 month

History of presenting illness

Ms.AM presented with a 2 and ½ month history of repetitive intrusive thoughts, the content of which is whether some people are dead or alive and a fear that something bad might befall her. These thoughts were recognised by her as being excessive, irrational and caused distress to her. She was able to

state that these thoughts are a product of her own mind. They were associated with repeated actions such as clenching her fist and hitting her head , which she said was to control her thoughts; she would also insist that her mother repeatedly make phone calls to confirm whether certain people were actually dead. However despite attempting to, she was unable to fully control these repetitive thoughts and thereby experienced severe distress, low mood, preoccupation and loss of interest in other pleasurable activities. These symptoms also disrupted her daily routine significantly. However her biological functions of sleep and appetite were intact. There is also a history of her having expressed suicidal wishes, secondary to the distress that she experienced, however there was no history of her having attempted the same . Historically these symptoms were triggered by hearing the news of the death of her former classmate as well as the stress of her 12^{th} standard board exams. There is no history of head injury, seizures, false fixed beliefs, hearing non existent voices, mood syndrome, panic symptoms or any specific phobias.

Past history

No significant past medical or psychiatric history

Family history

There is family history of late onset psychosis in her paternal grandfather and a probable episode of melancholic depression in her mother. She is the only child brought up in a nuclear family. There is a history of her being brought up in an

overprotective household with her mother dropping her to school (which was in the adjacent street) upto class XII. Her mother feeds her at home. There is a history of marital discord in her parents, however they deny fighting in front of her.

Birth and development history

The antenatal and perinatal periods were uneventful. The developmental milestones were reported to be normal. From early childhood she was described to have a difficult temperament. Her emotional regulation was poor. She had low frustration tolerance. Acting out tendencies were present. There was a tendency to cling onto mother due to her high dependency needs. Her self-care skills were fairly adequate. Her social interaction was minimal.

Sexual history

She attained menarche at the apprpprioate age and cycles are regular. She has heterosexual orientation. She denied any high risk sexual behaviour.

Educational history

She completed her 12^{th} standard in the commerce stream in March 2016. She was regular to school. She was hardworking and conscientious. She had few friends and preferred to be on her friends. She does not describe herself as being particularly close to any teacher or classmate at school. She was anxious

about meeting and interacting with new people. Her academic performance was good with the predominant method of learning being by rote.

Hobbies and interests

She did not engage in peer related activities and had very few friends. Most of her free time was spent at home, in the company of her mother. Her hobby was to watch Tamil Television soaps. She also had interest in writing poetry.

Physical examination

His vitals were stable. Systemic examination was within normal limits.

Mental status examination

The patient was moderately built, overweight, adequately kempt individual. Eye contact was adequate but rapport could not be established. No abnormal movements were noted. Her speech was spontaneous with normal productivity and good comprehension. Her mood was dysphoric with an inappropriate affect. Examination of content of thought revealed multiple obsessions and distress secondary to it, depressive ideas of hopelessness about the future due to her illness and helplessness regarding her present situation. Wishes to die were present but no active suicidal plans were made. Compulsions including fist clenching, hitting her head, cleaning and arranging and proxy compulsions were present. Her higher mental functions were intact. Her intelligence was average, insight limited and her judgement was impaired.

Provisional diagnosis

1. Obsessive Compulsive Disorder- Mixed Type
2. Delusional Disorder
3. Melancholic Depression with Obsessive- Compulsive symptoms

Aims for psychological testing

For diagnostic clarification and to rule out or establish psychosis.

Tests administered

- Brief Psychiatric Rating Scale (BPRS)
- Hamilton Depression Rating Scale (HAM-D)
- YBOCS (Yale Brown Obsessive Compulsive Scale)
- Sack's Sentence Completion Test
- Thematic Apperception Test
- Rorschach's Ink Blot Test

Behavioural Observation:

She was cooperative for the assessment and was able to sustain attention through the session. There was no performance anxiety observed. She was able to comprehend the instructions well. Her verbal communication was adequate.

Rationale for the tests & test results

Brief Psychiatric Rating Scale (BPRS)

- **Rationale:** The BPRS was developed by Gorham and Overall. It is a widely used instrument for assessing the positive, negative, and affective symptoms of individuals who have psychotic disorders, especially schizophrenia. It has proven particularly valuable for documenting the efficacy of treatment in patients who have moderate to severe disease.
- **Test Finding:** She scored 43 on the BPRS scale. She had high scores for anxiety, depressed mood and agitation.

Hamilton Rating Scale for Depression (HAM-D)

- **Rationale:** It was first introduced by Max Hamilton for rating the severity of Depression. It is a multi item questionnaire and each item is scored on a scale of 3-5. It is considered the gold standard tool for research.
- **Test Findings:** She scored 21 on the HAM-D scale, scoring high for OC symptoms, diurnal variation of symptoms and anxiety.

Yale Brown Obsessive Compulsive Scale (Y-BOCS)

- **Rationale:** Designed by Wayne.K. Goodman and colleagues.
- **Test Findings:** She scores a total of 38/40 (obsession score-19, compulsion score-19) indicating Extreme OCD- Mixed Type.

Sack's Sentence Completion Test

- **Rationale:** Sacks Sentence Completion Testis a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.
- **Test Finding:** It indicates conflicts in the area of family, interpersonal relationships and self. She has a positive attitude towards both her parents however is fearful of her father's punitive nature. There are feelings of emotional insecurity forcing her to have an enmeshed relationship with her mother. She longs for materialistic processions. There also appears to be some interpersonal conflicts with her friends and is unable to form close friendships. Has difficulty in forming trusting relationships. Most of her responses also reveal anxiety and apprehension in social situations. Low self- esteem and feelings of inadequacy are present. Her attitude towards sex is conservative. She appeared to have a rigid outlook about life and lacked flexibility in thinking.

Thematic Apperception Test

- **Rationale:** Thematic Apperception Test is a projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others
- **Test Finding:** The stories are not elaborative. She attributed personalized meanings to the stories. The predominant needs were those of recognition, affiliation, succorance and acquisition. Issues related to attachment, need for nurturance and approval were evident. The defence mechanisms portrayed are avoidance and reaction formation. She had rigidity in her thought process and had difficulty in perceiving situations in alternate ways. There were significant indicators of anxiety and inability to face challenges leading to emotional reactions. The predominant press is one of financial constraints. She did not have a favourable view of her environment which she perceived as threatening. The content of her stories did not reflect bizarre themes and were at the concrete level.

Rorschach's Ink Blot Test

- **Rationale:** The Rorschach Inkblot Test which was created by Hermann Rorschach in 1921, provides an understanding of structure of the

personality, affectional needs and ego strength. It also indicates degree of psychopathology.

- **Test Finding:** In the Rorschach protocol she has given 24 responses indicating normal productivity. Her reaction time was quick. The form level was good with a large number of whole and large detail responses. No fluctuations in form detail were noted. There were small detail responses with good form level. With respect to content it was predominantly animal followed by nature and human movement responses. There were indicators of anxiety in some of her responses where she emphasized on death and decay. Colour responses were adequately represented indicating absence of depressive elements. Emotional intolerance was evident in her reaction to colour shading. Her popular responses were adequate in number indicating adequate ties with reality. There was only 1 instance where card V failed to elicit a popular response. There were no signs of contamination or confabulation. Bizzare content was not evident. Her responses were not suggestive of psychotic phenomena although Obsessive and anxiety elements were present.

Summary of Test Finding

She appears to have features suggestive of an Obsessive Compulsive Disorder as well as an underlying anxiety disorder. Her reality orientation is adequate

however her thought patterns are rigid and she is unable to process information in a flexible manner. In view of this there are significant conflicts in the interpersonal situations leading to isolation and rejection. Emotional regulation is poor and her underlying personality organization is weak. Hence there is a tendency towards strong dependency needs which prevent her from developing a mature personality.

Management

Ms. A was admitted for a diagnostic clarification and rationalisation of medication. Following serial mental status examinations and psychological assessment, differentials of psychosis and melancholic depression were ruled out and a diagnosis of Obsessive Compulsive Disorder- Mixed type was made. She was taught relaxation techniques including deep breathing and JPMR- Jacobson's Progressive Muscular Relaxation. She was also taught distraction techniques to divert her thoughts away from the obsessions. Gradually an attempt was made to do Exposure and Response Prevention. However she was uncooperative for the same. Therefore supportive psychotherapy, relaxation and distraction techniques were used as the main modalities of therapy. She was also taught anger management principles which she was able to implement.

Pharmacologically she was treated with Fluoxetine. Despite a full trial of Fluoxetine, her symptoms persisted and therefore a change of SSRI to

Sertraline was considered. She showed minimal response to Sertraline which was given up to 150mg/day. Low dose of Risperidone was added to control agitation secondary to the distress she experienced and was subsequently tapered and stopped.. Benzodiazepines were also given for sedation and control of agitation. It was gradually tapered off.

Her parents were psychoeducated. Their parenting strategies were probed into and they were taught regarding parenting of an adolescent. Problem solving was emphasized upon.

In the follow up, we plan to address issues related to their marital disharmony.

CASE RECORD 4: DIAGNOSTIC CLARIFICATION

Name	: Mr. VC
Age	: 21years
Gender	: Male
Marital status	: Single
Religion	: Hindu
Language	: Tamil
Education	: B. Tech – discontinued after III year
Occupation	: Unemployed
Socio-economic status	: Middle
Residence	: Urban
Informant	: Mr. VC and his parents

Presenting complaints

- Cannabis use – three years
- Alcohol use -- three years
- Nicotine use -- three years
- abnormal beliefs – six months

History of presenting illness

Mr VC presented with a history of insidious onset of illness characterised by bizarre beliefs that his parents were no this real parents and that he was a robot

and he had been sent to earth for a mission. He claimed that his mission was now over and hence frequently asked his parents to kill him. He claimed that he had a connection to the creatures in the earth and birds and animal provided answers to questions that he thought of. He claimed that other people, both known and unknown, made fun of him and talked about him when he went out of the house. He held these beliefs firmly and they were unshakeable even when adequate proof against them were given to him. He also claimed that his thought were often known to other people and that they asked him about what he had thought of. He, however, did not answer how they were able to do it. He had poor sleep at night and would often stay awake till the early hours of the next day. His appetite was poor and he often refused to take food based on his delusion that he was a robot and did not need food to survive.

There is history of cannabis use for four years in a dependence pattern. He smoked about half a joint a day and on occasion more. There is also history of alcohol in harmful use pattern and nicotine in dependence pattern. Secondary to his substance use, there was impairment in his academic functioning and he was caught smoking cannabis in hostel and was evicted from his hostel. He was caught smoking cannabis again and was asked to discontinue from his college two years ago. There was also a history of frequent demands for money from his parents and a history of the patient threatening deliberate self harm when these demands weren't met. His last use of cannabis and alcohol were two months ago and his psychotic symptoms persisted even in the absence of these substances. There is history of experimenting with Lysergic Acid Diethylamide

(LSD) once and with psilocybin around three to four times over the last two years. The exact pattern of substance use was unclear as there were discrepancies in the reports provide by the patient and his parents.

There was no history of head injury seizures, manic or depressive syndromes or obsessive compulsive symptoms.

Past history

No significant past medical history

Family history

His father was real estate businessman and his mother was a home maker. He has an elder sister who was an engineer and worked for a software company in Madras. He was closer to his mother than to his father, although both parents were permissible in their upbringing of him. There was no family history of any neuro-psychiatric illness in his family.

Birth and development history

The antenatal and perinatal periods and were uneventful. The developmental milestones were reported to be normal.

Educational history

He had studied up to III year of Bachelor' in Technology. He discontinued studies due to issues with his behaviour in the college and hostel. He was

reported to be an above average student in school but his performance in college deteriorated due to his substance use.

Occupational history

He was unemployed.

Sexual history

He had heterosexual orientation. He denied high risk sexual behaviour. He denied sexual dysfunction currently.

Marital history

He was unmarried.

Premorbid personality

Premorbidly was reported to have been stubborn, adamant with low frustration tolerance. He was irresponsible and had novelty seeking behaviour. He was not religious.

Physical examination

His vitals were stable and systemic examination was within normal limits.

Mental status examination

Mr VC was thinly built, appropriately groomed and rapport could be established. He was alert and lucid. There were no abnormal movements. He was able to comprehend simple and complex instructions easily. His speech was slow and hesitant with good comprehension. His mood was euthymic with normal range and delayed reactivity. He denied suicidal ideation. There were no abnormalities in the form and stream of thought. Examination of content of thought revealed referential and other bizarre delusions. He reported second person auditory hallucinations of birds talking to him. He was oriented to time, place and person. His immediate, recent and remote memory was intact. He appeared preoccupied on occasions. His intelligence was average and his insight was impaired. His test judgement was intact and his social and personal judgement was impaired.

Provisional diagnosis

1. Undifferentiated Schizophrenia, period of observation less 1 year
2. Cannabis Related Psychotic Disorder schizophrenia like
3. Polysubstance abuse
4. Dissocial personality traits

Aims for psychological testing

For diagnostic clarification and to rule out or establish psychosis.

Tests Administered and rationale

1. **Rorschach's Ink Blot Test**

Rationale: The Rorschach Inkblot Test provides an understanding of structure of the personality, affectional needs and ego strength. It also indicates degree of psychopathology.

2. **Sack's Sentence Completion Test**

Rationale: Sacks Sentence Completion Testis a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

3. **Thematic Apperception Test**

Rationale: Thematic Apperception Test is a projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others

4. **Brief Psychiatric Rating Scale (BPRS)**

Rationale: The BPRS was developed by Gorham and Overall. It is a widely used instrument for assessing the positive, negative, and affective symptoms of individuals who have psychotic disorders, especially schizophrenia. It has proven particularly valuable for documenting the efficacy of treatment in patients who have moderate to severe disease.

Behavioural Observation

He was cooperative for the assessment and was able to sustain attention through the session. There was no performance anxiety observed. He was able to comprehend the instructions well. His verbal communication was adequate.

Test Results

Rorschach's Ink Blot Test

In the Rorschach protocol he has given 48 responses indicating over productivity with normal mentation. The protocol indicates that there is a balance between his impulsivity and value system. His inner conflicts interfere in his day to day functioning and his ability to handle problems. It indicates denial and repression of underdeveloped need for affection. Despite a capacity to react satisfactorily to environmental

stimuli, he tends to not do so due to repression of his own emotions reactions. He tend to have high ambitions without the sufficient qualities to back it up. There is high number of Hd responses indicating anxiety and a tendency to avoid social interaction. High number of unusual details, fluctuation in form level high sum C score, high percentage of space responses and high percentage of W with poor form quality is suggestive of the presence of an underlying psychosis

Sack's Sentence Completion Test

It indicates a conflict primarily in the area of family. There appears to be significant conflicts in his attitude towards his parents, especially his mother who he feels is cruel. While there does seem to be a conflict with his father as well, it seems like he is less hostile towards him. He has a sense of estrangement from his family. There is guilt regarding various aspects of his behaviour in the past. He appears to have little goals for himself in the future with his attitude appearing very casual towards his future indicating a sense of irresponsibility. While he believes he has the capacity to excel at things, he tends to give up easily when the odds are stacked up against him indicating low self confidence. He is happy reminiscing about his past and seems hopeful for the future. However, he feels unsettled about the present and feels that he would be better off if left alone. He seems to be seeking answers about himself. He also

talks of drugs helping him at work. His attitude towards sex seems ambiguous and casual.

Thematic Apperception Test

Most of the stories are brief. He does not identify himself with the hero in most of the stories. The dominant needs that are expressed are need for autonomy, achievement, aggression, sex and harm avoidance. The major press that are seen are poverty and insecurity. A need for affection from and deference to the mother is also prominent which tends to mirror his relationship with his own mother. There is stark difference in the portrayal of the heroes in the stories. While some of the heroes are portrayed as characters with a strong sense of familial ties others are portrayed as insecure and with poor moral standards. The dominant emotions present are confidence, guilt, and anger. The conflicts noted are mainly harm avoidance vs aggression and need for achievement and autonomy vs nurturance and deference. A majority of the stories have a pessimistic outcome.

Brief Psychiatric Rating Scale (BPRS)

His total baseline score in the BPRS was 45. He had high scores on suspiciousness, bizarre behavior, unusual thought content and hallucinations.

Summary of Test Finding

The projective assessment was suggestive of psychosis. The TAT and SCT indicated strong ties and attachment towards the mother.

Management

Mr. VC was admitted for diagnostic clarification. Projective and psychometric tests were used to establish a diagnosis of Undifferentiated Schizophrenia. EEG and MRI scan helped rule out any organic aetiology. Subsequently he was initiated on an antipsychotic drug trial (Olanzapine) which was titrated upto a maximum dose of 25mg/day. While admitted as an in patient, he did not express any craving for the illicit substances. The risk of relapse of psychotic symptoms subsequent to substance use was discussed with him. He was psychoeducated and relapse prevention strategies were discussed. Discussions with regards to vocational rehabilitation were held. He was discharged with a plan for frequent out patient follow ups.

CASE RECORD 5: NEUROPSYCHOLOGICAL ASSESSMENT

Name	: Mr. PG
Age	: 39 years
Sex	: Male
Marital status	: Married
Religion	: Hindu
Language	: Bengali
Education	: Primary School (5th standard)
Occupation	: Tea Shop owner
Socio-economic status	: Middle
Residence	: Rural
Informant	: Mr. PG and his brother

Presenting complaints

One episode of seizure	- One month prior to presentation
Decline in memory	- One month
Decline in functioning	- One month

History of presenting illness

Mr. PG presented with a history of one episode of unprovoked seizure one month ago and the seizure semiology was of generalized clonic tonic type characterised by up-rolling of eyes, frothing at the mouth, with loss of consciousness and resulting in a fall. He was reported to have been

unconscious for about 10-15 minutes before he was found by bystanders. Following the seizure he was in a state of disorientation and confusion for around five hours. Mr PG had amnesia for the episode. There have been no further episodes of seizures. Subsequently, over the last one month he is reported to have impaired memory, difficulty in daily activities such as handling money, and difficulty in execution of routine tasks. However the family reported no fluctuation in orientation or consciousness. These symptoms have led to a marked impairment of his socio-occupational functioning.

He was evaluated outside and a CT scan was done which revealed no abnormality. He was started on treatment from outside on a combination of anti-epileptic (Phenytoin, Sodium Valproate, Clobazam) and antipsychotic medication (Olanzapine) along with Trihexyphenidyl.

He also has a history of nicotine use in dependence pattern for over two years.

There is no history of fever, headache, vomiting or head injury prior to the seizure episode. There is no history of febrile seizures or status epilepticus in childhood. There is no history of any other psychoactive substance use. There is no history suggestive of psychosis, pervasive mood syndrome, and obsessive compulsive or anxiety symptoms.

Past history

No significant past medical history.

Family history

There is no family history of any neuro-psychiatric illness in his family.

Birth and development history

The antenatal and perinatal periods were uneventful. The developmental milestones were reported to be normal.

Educational history

He has studied up to class V. He was described to be average in academics. His relationship with his peers and his teachers was reported to be warm.

Occupational history

He has been running a tea shop for about the last twenty years.

Sexual history

He has heterosexual orientation. He denied any history of premarital high risk sexual behaviour. He denied sexual dysfunction currently.

Marital history

He is married and it is a non consanguineous marriage. His wife is 35 years old and is a house wife. The couple has three daughters.

Premorbid personality

Premorbidly he is said to have had anxious avoidant traits. He is said to have been hard working and had high religious and moral standards.

Physical examination

His vitals were stable and his systemic examination was within normal limits.

Central nervous system

Cranial nerves – No cranial nerve palsies

Motor system

Bulk - Normal bilaterally

Tone - Normal tone bilaterally

Power - Grade 5 power bilaterally

Bilateral fine tremors in both hands

Sensory system

Crude touch, Pain, Temperature - Normal bilaterally

Light touch, Vibration and Joint position sense - Normal bilaterally

Reflexes

Superficial abdominal reflex - Present all four quadrants

Plantar reflex - Flexor bilaterally

Deep tendon reflexes - 2+ bilaterally

Cerebellar functions - No signs of cerebellar dysfunction

No signs of meningeal irritation

Examination of skill and spine was normal

Gait – normal

Mental status examination

He was a moderately built and appropriately kempt individual. He maintained intermittent eye contact through the interview. Rapport was difficult to establish and remained shallow. He was alert, lucid with no fluctuations in consciousness. He was cooperative through the interview. He was able to carry out simple one step commands, but was unable to carry out complex three step commands. He had psychomotor retardation with diminished reactive movements. However his goal directed movements were appropriate and purposeful. He had fine tremors of both hands. His speech was hesitant and monotonous but fluent, audible, relevant in content with increased reaction time. His mood was dysphoric with affective blunting. There were no abnormalities in the form and stream of thought. His content of thought revealed distress secondary to his memory impairment. He had no perceptual or volitional abnormalities. He was oriented to time, place and person. However his immediate, recent and remote memory was impaired. His attention could be aroused but not sustained. His intelligence was found to average. His insight into his problems and judgement were intact.

Provisional diagnosis

With this a provisional diagnosis of one episode of generalized seizure with sudden onset, post ictal cognitive decline under evaluation was considered.

Aims for neuropsychological testing

1. To find out the cognitive profile of Mr. PG
2. To relate the findings to clinical presentation

Tests Administered and Rationale

- **NIMHANS Neuropsychological Battery**
- **Rationale:** The battery was developed by Shobini Rao et al. This assesses a subject's performance across various domains of neuropsychological functions. It has been validated to suit the Indian adult population.

Behavioural Observation

He was cooperative for the assessment but had difficulty in sustaining his attention over the course of the assessment. Therefore the assessment had to be held over separate sessions. There was no active resistance in doing the assessment. He was able to comprehend the instructions well. His verbal communication was limited. There was no performance anxiety observed.

TEST RESULTS

NIMHANS Neuropsychological Battery

Mental speed

On the digit symbol substitution test, the total time taken to complete was 2130s which is below the 3rd percentile, indicative of significant impairment in mental speed.

Sustained attention

On the digit vigilance test, the total time taken to complete was 1425s which is below the 3rdpercentile. The total errors are 23 which is at the 8th percentile, indicative of significant impairment in sustained attention.

Focussed Attention

On the Colour Trails Test-- 1, the total time taken to complete was 210s which is below the 3rd percentile and the total time taken to complete Colour Trails Test – 2 was 631s which is also below the 3rd percentile. Both are indicative of significant impairment in focussed attention.

Divided Attention

On the Triads Test, the total errors was 14, which is at the 3rd percentile, indicative of impairment in his ability to divide his attention between two tasks requiring different sensory modalities. He was able to focus his attention on only one of the tasks he was instructed to do.

Executive functions

- **Phonemic fluency**

  Phonemic fluency was assessed by the Controlled Oral Word Association Test (COWAT). On the COWAT, the average number of new words generated was 4.5 which is at the 15th percentile and is indicative of impairment in phonemic fluency.

- **Categorical fluency**

  Was assessed by the Animal Names Test. The total new words generated was 10, which is at the 20th percentile, indicative of mild impairment in categorical fluency.

  Better performance in the animal names test than in the COWAT is suggestive of impaired verbal executive skills.

- **Working memory**

  Working Memory was assessed using the Verbal N back Test. The number of 1 back hits was 6 and errors was 3, which fall at the 5th and 33rd percentiles respectively. The number of 2 back hits was 3 and errors was 7, which fall at the 5th and 17th percentiles respectively. This is indicative of impairment of working memory.

Verbal Learning and Memory

On the auditory verbal and learning test, the total number of correct words recalled is 24, which is below the 5th percentile; the immediate recall and delayed recalls are at 0 and 2 words which are both <5th percentile. The long term percentage retention is 25%. The number of hits in the recognition trial is 11 which is at the 5th percentile. This indicates the presence of deficits in verbal learning and memory. His recognition also is impaired. This is indicative of deficits in both recall and storage of information.

Visuo- spatial construction and visual learning and memory

On the ROCF, the copying score is 18, which is below the 5th percentile. The immediate recall score is 3 which is below the 5th percentile and the delayed recall is impaired as well (<5th percentile). This indicates impairment in visuo-constructive ability and visual memory.

Impression

The test findings indicate significant impairment in almost all domains of functioning. However, the level of deficits are out of proportion to that of what would be expected after a single episode of seizure. In view of the disproportionate findings and the intact language, a functional illness may be considered after ruling out structural abnormalities with imaging.

Management

In view of the acute onset cognitive decline following an episode of generalized seizure, a neurology evaluation was considered. The patient was advised to do basic blood investigations including total and differential counts, Electrolytes, Vitamin B12 and Folate levels, Neurophysiological test – EEG and neuroimaging in the form of an MRI. With the above he was advised to obtain a neurology consultation. An MRI was done with nil abnormality. For his distress, he was prescribed Tab. Escitalopram 5mg/day. Following initiation of therapy there was a dramatic improvement of symptoms suggesting a possible a functional etiology.